FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0030551

Facility Name: BRIGHTVIEW CARE CENTER

Address: 4538 N. BEACON (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 275-7200 **Fax #** (773) 275-7543

IDPA ID Number: 363408520001

Date of Initial License for Current Owners: 02/01/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) CARY N. DRAZNER, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	143	Skilled (SNF)	143	52,195	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	143	TOTALS	143	52,195	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	32,788	1,577	2,364	36,729	8
9	SNF/PED					9
10	ICF	10,886			10,886	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,674	1,577	2,364	47,615	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.23%

D. How many bed-hold days during this year were paid by Public Aid?
1192 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 1650

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	171,556	23,589	8,600	203,745		203,745		203,745			1
2	Food Purchase		228,828		228,828	(20,641)	208,187	(75)	208,112			2
3	Housekeeping	184,397	62,195		246,592		246,592	678	247,270			3
4	Laundry	80,441	16,499		96,940		96,940		96,940			4
5	Heat and Other Utilities			115,236	115,236		115,236	2,408	117,644			5
6	Maintenance	51,949	24,285	42,144	118,378		118,378	(3,346)	115,032			6
7	Other (specify):*							26	26			7
8	**TOTAL General Services**	488,343	355,396	165,980	1,009,719	(20,641)	989,078	(309)	988,769			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,470,934	114,119	7,703	1,592,756		1,592,756	187	1,592,943			10
10a	Therapy	110,708	282	27,107	138,097		138,097		138,097			10a
11	Activities	69,152	5,590	807	75,549		75,549		75,549			11
12	Social Services	99,496		7,467	106,963		106,963		106,963			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,750,290	119,991	47,884	1,918,165		1,918,165	187	1,918,352			16
	C. General Administration											
17	Administrative	181,944		37,000	218,944		218,944	60,375	279,319			17
18	Directors Fees											18
19	Professional Services			321,719	321,719	(4,183)	317,536	(200,706)	116,830			19
20	Dues, Fees, Subscriptions & Promotions			37,487	37,487		37,487	(9,211)	28,276			20
21	Clerical & General Office Expenses	171,296	40,185	266,152	477,633		477,633	(159,959)	317,674			21
22	Employee Benefits & Payroll Taxes			367,133	367,133	20,641	387,774	(426)	387,348			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,620	1,620		1,620	32	1,652			24
25	Other Admin. Staff Transportation			619	619		619	82	701			25
26	Insurance-Prop.Liab.Malpractice			104,550	104,550		104,550	789	105,339			26
27	Other (specify):*							29,280	29,280			27
28	**TOTAL General Administration**	353,240	40,185	1,136,280	1,529,705	16,458	1,546,163	(279,744)	1,266,419			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,591,873	515,572	1,350,144	4,457,589	(4,183)	4,453,406	(279,866)	4,173,540			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BRIGHTVIEW CARE CENTER #0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			53,054	53,054		53,054	59,375	112,429			30
31	Amortization of Pre-Op. & Org.							4,277	4,277			31
32	Interest			53,114	53,114		53,114	112,127	165,241			32
33	Real Estate Taxes					4,183	4,183	127,937	132,120			33
34	Rent-Facility & Grounds			411,792	411,792		411,792	(411,792)				34
35	Rent-Equipment & Vehicles			9,890	9,890		9,890	978	10,868			35
36	Other (specify):*											36
37	**TOTAL Ownership**			527,850	527,850	4,183	532,033	(107,098)	424,935			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		22,764	59,028	81,792		81,792		81,792			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,293	78,293		78,293		78,293			42
43	Other (specify):*	99,622			99,622		99,622	(99,622)				43
44	**TOTAL Special Cost Centers**	99,622	22,764	137,321	259,707		259,707	(99,622)	160,085			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,691,495	538,336	2,015,315	5,245,146		5,245,146	(486,586)	4,758,560			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(53,832)	30		9
10	Interest and Other Investment Income	(100)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(75)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(33)	21		18
19	Entertainment				19
20	Contributions	(3,820)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(232,299)	21		24
25	Fund Raising, Advertising and Promotional	(2,919)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(118,587)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (411,665)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(74,921)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (74,921)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (486,586)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BRIGHTVIEW CARE CENTER

ID# 0030551

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized Repairs & Maintenance	$ (6,471)	6	1
2	Marketing Salary	(99,322)	43	2
3	Resident Gifts	(426)	22	3
4	Theft & Loss	(518)	21	4
5	Bank Charges	(900)	21	5
6	Bank Charges - Building Company	(510)	21	6
7	Penalty - Building Company	(1,100)	21	7
8	C.O.P.E.	(3,015)	20	8
9	Non-allowable Seminar Expense - 1999	(290)	24	9
10	Non-reimbursable Accounting Fee	(5,000)	19	10
11	Non-allowable seminar expense - Marketing	(235)	24	11
12	Non-allowable Marketing bonus	(300)	43	12
13	Non-allowable Mortgage Refinancing Survey	(500)	19	13
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(75)											(75)	2
3	Housekeeping			678									678	3
4	Laundry													4
5	Heat and Other Utilities			1,103		1,305							2,408	5
6	Maintenance	(6,471)		2,545		580							(3,346)	6
7	Other (specify):*					26							26	7
8	**TOTAL General Services**	(6,546)		4,326		1,911							(309)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			187									187	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**			187									187	16
	C. General Administration													
17	Administrative			53,475	6,400	500							60,375	17
18	Directors Fees													18
19	Professional Services	(5,500)		(195,851)	286	359							(200,706)	19
20	Fees, Subscriptions & Promotions	(9,754)	75	416	36	16							(9,211)	20
21	Clerical & General Office Expenses	(235,360)	1,610	73,666	30	95							(159,959)	21
22	Employee Benefits & Payroll Taxes	(426)											(426)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(525)		557									32	24
25	Other Admin. Staff Transportation			82									82	25
26	Insurance-Prop.Liab.Malpractice			685		104							789	26
27	Other (specify):*			27,802	1,478								29,280	27
28	**TOTAL General Administration**	(251,565)	1,685	(39,168)	8,230	1,074							(279,744)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(258,111)	1,685	(34,655)	8,230	2,985							(279,866)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(53,832)	106,632	5,213	113	1,249							59,375	30
31	Amortization of Pre-Op. & Org.		4,277										4,277	31
32	Interest	(100)	109,641	265		2,321							112,127	32
33	Real Estate Taxes		126,212			1,725							127,937	33
34	Rent-Facility & Grounds		(411,792)	9,836		(9,836)							(411,792)	34
35	Rent-Equipment & Vehicles			978									978	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(53,932)	(65,030)	16,292	113	(4,541)							(107,098)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(99,622)											(99,622)	43
44	**TOTAL Special Cost Centers**	(99,622)											(99,622)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(411,665)	(63,345)	(18,363)	8,343	(1,556)							(486,586)	45

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached		See attached		See attached		
				Brightview Bldg Co.	Chicago	Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 265,392	BRIGHTVIEW BUILDING CO.	100.00%	$	$ (265,392)	1
2	V	34	RENTAL INCOME - R/E TAX	146,400	BRIGHTVIEW BUILDING CO.	100.00%		(146,400)	2
3	V	32	INTEREST INCOME	1,650	BRIGHTVIEW BUILDING CO.	100.00%		(1,650)	3
4	V	32	MORTGAGE INTEREST EXP		BRIGHTVIEW BUILDING CO.	100.00%	111,291	111,291	4
5	V	30	DEPRECIATION		BRIGHTVIEW BUILDING CO.	100.00%	106,632	106,632	5
6	V	31	AMORTIZATION		BRIGHTVIEW BUILDING CO.	100.00%	4,277	4,277	6
7	V	33	R/E TAX		BRIGHTVIEW BUILDING CO.	100.00%	126,212	126,212	7
8	V	20	ANNUAL FEE		BRIGHTVIEW BUILDING CO.	100.00%	75	75	8
9	V	21	BANK CHARGES		BRIGHTVIEW BUILDING CO.	100.00%	510	510	9
10	V	21	PENALTY		BRIGHTVIEW BUILDING CO.	100.00%	1,100	1,100	10
11	V								11
12	V								12
13	V								13
14	Total			$ 413,442			$ 350,097	$ * (63,345)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	MANAGCARE, INC.	100.00%	$ 678	$ 678	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,103	1,103	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	2,545	2,545	17
18	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%	187	187	18
19	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	50,386	50,386	19
20	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	1,489	1,489	20
21	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	416	416	21
22	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	73,666	73,666	22
23	V	24	SEMINARS		MANAGCARE, INC.	100.00%	557	557	23
24	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	82	82	24
25	V	26	INSURANCE		MANAGCARE, INC.	100.00%	685	685	25
26	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	27,802	27,802	26
27	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	5,213	5,213	27
28	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	265	265	28
29	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	9,836	9,836	29
30	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	978	978	30
31	V	19	HOME OFFICE	197,340	MANAGCARE, INC.	100.00%		(197,340)	31
32	V	17	ADMIN. SALARY - MOSHE DAVIS		MANAGCARE, INC.	100.00%	713	713	32
33	V	17	ADMIN. SALARY - JOSHUA DAVIS		MANAGCARE, INC.	100.00%	2,376	2,376	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 197,340			$ 178,977	$ * (18,363)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	INTERCARE, LTD. C/O MANAGCARE	100.00%	$ 43,400	$ 43,400	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	286	286	16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	36	36	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	30	30	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	1,478	1,478	19
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	113	113	20
21	V								21
22	V	17	MANAGEMENT FEES	37,000	INTERCARE, LTD. C/O MANAGCARE	100.00%		(37,000)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 37,000			$ 45,343	$ * 8,343	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MAZEL MANAGEMENT	100.00%	$ 1,305	$ 1,305	15
16	V	6	REPAIRS & MAINT.		MAZEL MANAGEMENT	100.00%	580	580	16
17	V	7	EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT	100.00%	26	26	17
18	V	17	ADMIN.-M. WOLF		MAZEL MANAGEMENT	100.00%	500	500	18
19	V	19	PROFESSIONAL FEES		MAZEL MANAGEMENT	100.00%	359	359	19
20	V	20	FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT	100.00%	16	16	20
21	V	21	CLERICAL & GENERAL		MAZEL MANAGEMENT	100.00%	95	95	21
22	V	26	INSURANCE		MAZEL MANAGEMENT	100.00%	104	104	22
23	V	30	DEPRECIATION		MAZEL MANAGEMENT	100.00%	1,249	1,249	23
24	V	32	INTEREST EXPENSE		MAZEL MANAGEMENT	100.00%	2,321	2,321	24
25	V	33	REAL ESTATE TAXES		MAZEL MANAGEMENT	100.00%	1,725	1,725	25
26	V	34	RENT	9,836	MAZEL MANAGEMENT	100.00%		(9,836)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,836			$ 8,280	$ * (1,556)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Davis	Owner	Administrative	72.34%	See Attached	10.00	16.67%	Salary	$ 15,000	17-1	1
2	Yosef Davis							Inter Care	43,400	17-7	2
3	Moshe Davis	Dir of Operations	Administrative		See Attached	4.10	10.25%	Salary	14,365	17-1	3
4	Moshe Davis							Inter Care	713	17-7	4
5	Joshua Davis	Administrator	Administrative		See Attached	13.40	33.50%	Salary	48,989	17-1	5
6	Joshua Davis							Inter Care	2,376	17-7	6
7	Shoshana Braun	Relative	Clerical		See Attached	4.50	13.35%	Salary	3,875	21-1	7
8	Moshe Wolf	Owner	Administrative	2.13%	See Attached	11.00	19.64%	ManagCare	13,499	17-7	8
9	Moshe Wolf							Mazel	500	17-7	9
10	Stanley Klem	Owner	Administrative	2.13%	See Attached	8.00	20.00%	ManagCare	22,072	17-7	10
11											11
12											12
13								TOTAL	$ 164,789		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MANAGCARE, INC.
Street Address: 3553 W. PETERSON AVE -3RD FLR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOKEEPING INC.	1,010,160	4	$ 3,472	$	197,340	$ 678	1
2	5	UTILITIES	BOOKEEPING INC.	1,010,160	4	5,647		197,340	1,103	2
3	6	REPAIRS AND MAINT.	BOOKEEPING INC.	1,010,160	4	13,027		197,340	2,545	3
4	10	NURSING SALARIES	BOOKEEPING INC.	1,010,160	4	956	956	197,340	187	4
5	17	ADMINISTRATIVE	BOOKEEPING INC.	1,010,160	4	257,918	257,918	197,340	50,386	5
6	19	PROFESSIONAL FEES	BOOKEEPING INC.	1,010,160	4	7,622		197,340	1,489	6
7	20	FEES, SUBSCRIPTIONS	BOOKEEPING INC.	1,010,160	4	2,131		197,340	416	7
8	21	CLERICAL AND GENERAL	BOOKEEPING INC.	1,010,160	4	377,089	309,593	197,340	73,666	8
9	24	SEMINARS	BOOKEEPING INC.	1,010,160	4	2,850		197,340	557	9
10	25	ADMIN. STAFF TRANS.	BOOKEEPING INC.	1,010,160	4	419		197,340	82	10
11	26	INSURANCE	BOOKEEPING INC.	1,010,160	4	3,506		197,340	685	11
12	27	GEN. ADMIN. EMP. BEN.	BOOKEEPING INC.	1,010,160	4	142,315		197,340	27,802	12
13	30	DEPRECIATION	BOOKEEPING INC.	1,010,160	4	26,685		197,340	5,213	13
14	32	INTEREST EXPENSE	BOOKEEPING INC.	1,010,160	4	1,357		197,340	265	14
15	34	RENT - BUILDING (RELATED)	BOOKEEPING INC.	1,010,160	4	50,350		197,340	9,836	15
16	35	EQUIPMENT RENTAL	BOOKEEPING INC.	1,010,160	4	5,005		197,340	978	16
17										17
18	17	ADMIN. SALARY - MOSHE DA	AVG HRS WORKED	40	4	6,985	6,985	4	713	18
19	17	ADMIN. SALARY - JOSHUA DA	AVG HRS WORKED	40	4	7,104	7,104	13	2,376	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 914,438	$ 582,556		$ 178,977	25

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: INTERCARE, LTD. C/O MANAGCARE
Street Address: 3553 W. PETERSON AVE. 3RD FLOOR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	AVG. HOURS WORKED	60	6	$ 260,400	$ 260,400	10	$ 43,400	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	60	6	1,715		10	286	2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	60	6	218		10	36	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	60	6	178		10	30	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	60	6	8,871		10	1,478	5
6	30	DEPRECIATION	AVG. HOURS WORKED	60	6	678		10	113	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 272,060	$ 260,400		$ 45,343	25

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MAZEL MANAGEMENT
Street Address: 3553 W.PETERSON AVE.
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	MNGCR. BOOKPNG. INC.	1,010,160	4	$ 6,681	$	197,340	$ 1,305	1
2	6	REPAIRS & MAINT.	MNGCR. BOOKPNG. INC.	1,010,160	4	2,971	1,747	197,340	580	2
3	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. BOOKPNG. INC.	1,010,160	4	134		197,340	26	3
4	17	ADMIN.-M. WOLF	MNGCR. BOOKPNG. INC.	1,010,160	4	2,559		197,340	500	4
5	19	PROFESSIONAL FEES	MNGCR. BOOKPNG. INC.	1,010,160	4	1,837		197,340	359	5
6	20	FEES, SUBSCRIPTIONS	MNGCR. BOOKPNG. INC.	1,010,160	4	82		197,340	16	6
7	21	CLERICAL & GENERAL	MNGCR. BOOKPNG. INC.	1,010,160	4	489		197,340	95	7
8	26	INSURANCE	MNGCR. BOOKPNG. INC.	1,010,160	4	531		197,340	104	8
9	30	DEPRECIATION	MNGCR. BOOKPNG. INC.	1,010,160	4	6,392		197,340	1,249	9
10	32	INTEREST EXPENSE	MNGCR. BOOKPNG. INC.	1,010,160	4	11,883		197,340	2,321	10
11	33	REAL ESTATE TAXES	MNGCR. BOOKPNG. INC.	1,010,160	4	8,830		197,340	1,725	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 42,389	$ 1,747		$ 8,280	25

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Manufacturer's Bank		X	Line of Credit			$	$ 250,000			$ 9,380	1
2	Manufacturer's Bank		X	Auto	$339	1/7/00	17,000	10,450		7.25%	896	2
3	Mid North Financial		X	Mortgage - Building Co.	$35,116			1,000,502		10.50%	111,291	3
4	PFS		X	Liab. Insurance Financing	$112	9/15/01			6/15/02	8.19%	3,364	4
5				(Balance included in A/P-Insurance)								5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$35,568		$ 17,000	$ 1,260,952			$ 124,931	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										836	10
11	Mid America	X									39,474	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 40,310	14
15	TOTALS (line 9+line14)						$ 17,000	$ 1,260,952			$ 165,241	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income		X				$	$			$ (100)	1
2	Interest Income - Building Co.	X									(1,650)	2
3	Allocation - ManagCare	X									265	3
4	Allocation - Mazel Management	X									2,321	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 836	21

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 150,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 137,937	2
3. Under or (over) accrual (line 2 minus line 1).		$ (12,063)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 140,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 4,183	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ 12,531 For 19 94 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 132,120	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	149,212	8
	1997	144,564	9
	1998	147,131	10
	1999	146,143	11
	2000	136,212	12

2001 Accrual = $136,212 X 1.025= $140,000 (rounded)

Refund has not been offset since it relates to a tax bill which was not used to calculate a rate.

Real estate tax allocated from Mazel Management - $1,725

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIGHTVIEW CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0030551

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-115-017-0000	Nursing Home Property	$ 54,253.16	$ 54,253.16
2.	14-17-115-018-0000	Nursing Home Property	$ 53,518.90	$ 53,518.90
3.	14-17-115-030-0000	Nursing Home Property	$ 28,439.98	$ 28,439.98
4.	See attached	Allocated - Managcare	$ 40,914.95	$ 1,832.78
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 177,126.99	$ 138,044.82

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 64,152
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 4,277
4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 73,992	1
2					2
3	TOTALS			$ 73,992	3

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	143		1986	1986	$ 1,899,326	$ 107,275	35	$ 54,266	$ (53,009)	$ 1,487,761	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1986	10,306		20	543	543	8,481	9
10	Various			1987	4,719		20	236	236	3,424	10
11	Various			1988	2,895		20	145	145	2,005	11
12	Various			1989	67,265		20	3,272	(3,272)	43,049	12
13	Various			1991	22,384		20	1,120	1,120	9,762	13
14	Various			1992	17,019		20	143	143	13,895	14
15	Various			1993	44,200		20	2,211	2,211	18,657	15
16	Various			1994	63,594		20	3,181	3,181	23,936	16
17	Various			1995	7,105		20	356	356	2,342	17
18	Various			1996	37,640		20	1,882	1,882	10,921	18
19	Various			1997	17,411		20	871	871	3,557	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		51,762	2,677		2,222	(455)	32,353	68
69	Financial Statement Depreciation			15,873			(15,873)		69
70	TOTAL (lines 4 thru 69)		$ 2,245,626	$ 125,825		$ 70,448	$ (61,921)	$ 1,660,143	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,245,626	$ 125,825		$ 70,448	$ (55,377)	$ 1,660,143	1
2	WATER LINE	1998	3,150		20	158	158	619	2
3	VARIOUS IMPR	1998	5,645		20	282	282	987	3
4	COOLING TOWER	1998	2,175		20	109	109	363	4
5	PAINTING	1998	3,500		20	175	175	700	5
6	SPRINKLERS	1998	1,370		20	69	69	219	6
7	ALARM SYSTEM	1998	4,331		20	217	217	687	7
8	REPAIR GENERATOR	1998	850		20	43	43	133	8
9	COOLING TOWER	1998	700		20	35	35	117	9
10	CCTV SYSTEM	1998	3,552		20	178	178	593	10
11	CARPET	1998	890		20	45	45	161	11
12	ELEVATOR REPAIR	1998	1,600		20	80	80	267	12
13	PAINT	1998	662		20	33	33	118	13
14	SCREENS	1998	655		20	33	33	116	14
15	WALLPAPER	1998	623		20	31	31	114	15
16	PAINT	1998	497		20	25	25	96	16
17	PAINT	1998	997		20	50	50	196	17
18	PAINT	1998	700		20	35	35	140	18
19	ELEVATOR FRAME	1998	1,007		20	50	50	196	19
20	2ND NURSING STATION	1998	3,250		20	163	163	489	20
21	BALLAST	1998	6,890		20	345	345	1,035	21
22	3RD NURSING STATION	1998	3,250		20	163	163	489	22
23	WINDOW TREATMENTS	1998	3,556		20	178	178	534	23
24	BOILER REPAIR	1999	2,500		20	125	125	354	24
25	GENERATOR	1999	100,000		20	5,000	5,000	12,917	25
26	WINDOWS	1999	58,097		20	2,905	2,905	7,505	26
27	DAMPERS & GRILLS	1999	19,323		20	966	966	2,496	27
28	LIFE SAFETY CONSULT	1999	930		20	47	47	121	28
29	CONSTRUCTION CONSULT	1999	2,980		20	149	149	385	29
30	EMERGENCY SYSTEM	1999	4,000		20	200	200	500	30
31	FIRE EQUIPMENT	1999	2,162		20	108	108	324	31
32	ELEVATOR	1999	4,600		20	230	230	594	32
33	FIREDOOR MASONRY	1999	4,200		20	210	210	490	33
34	TOTAL (lines 1 thru 33)		$ 2,494,268	$ 125,825		$ 82,885	$ (42,940)	$ 1,694,198	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,494,268	$ 125,825		$ 82,885	$ (42,940)	$ 1,694,198	1
2	EXHAUST FANS	1999	3,230		20	162	162	338	2
3	CCTV SYSTEM	1999	4,391		20	220	220	458	3
4	TELEPHONE SYSTEM	1999	730		20	37	37	77	4
5	ELECTRIC DOOR	1999	836		20	42	42	98	5
6	INTERCOM	1999	557		20	28	28	65	6
7	ASPHALT REPAIRS	1999	4,015		20	201	201	486	7
8	TUCKPOINTING	1999	1,350		20	68	68	181	8
9	ALARM SYSTEM	1999	1,583		20	79	79	224	9
10	SHAFT BEARING	2000	4,307		20	215	215	269	10
11	BOILER	2000	1,650		20	83	83	118	11
12	SHAFT BEARING	2000	2,344		20	117	117	156	12
13	EMERGENCY GENERATOR	2000	18,892		20	945	945	1,496	13
14	ELECTRIC CONNECTIONS	2000	6,326		20	316	316	342	14
15	COMPUTER CABLE RUN	2000	4,903		20	245	245	347	15
16	TELEPHONE LINES	2000	2,892		20	145	145	230	16
17	VIDEO MONITORING SYS	2000	3,615		20	181	181	362	17
18	RAMP RAILING EXTNSN	2000	1,000		20	50	50	79	18
19	COMM/ACS PROCESSOR	2000	1,346		20	67	67	112	19
20	KICKPLATES FOR DOORS	2000	559		20	28	28	35	20
21	ALARMS	2001	10,314		20	301	301	301	21
22	ELECTRICAL WORK	2001	2,740		20	80	80	80	22
23	REWIRE PATIO	2001	2,575		20	75	75	75	23
24	DOOR DETECTORS	2001	3,600		20	360	360	360	24
25	ELEVATOR VALVE	2001	2,900		20	97	97	97	25
26	MOTOR PANEL	2001	1,800		20	30	30	30	26
27	CIRCUIT & OUTLET	2001	1,195		20	5	5	5	27
28	CCTV MONITOR	2001	1,206		20	10	10	10	28
29	CCTV BASEMT MONITOR	2001	1,037		20	4	4	4	29
30	DOOR EDGE PROTECTORS	2001	2,318		20	106	106	106	30
31	WALL HEATER	2001	696		20	3	3	3	31
32	A/C REPAIR	2001	1,185		20	39	39	39	32
33	MOTOR	2001	847		20	14	14	14	33
34	TOTAL (lines 1 thru 33)		$ 2,591,207	$ 125,825		$ 87,238	$ (38,587)	$ 1,700,795	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,591,207	$ 125,825		$ 87,238	$ (38,587)	$ 1,700,795	1
2	ELEVATOR PARTS	2001	1,721		20	57	57	57	2
3	ELEVATOR REPAIRS	2001	900		20	23	23	23	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,593,828	$ 125,825		$ 87,318	$ (38,507)	$ 1,700,875	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,593,828	$ 125,825		$ 87,318	$ (38,507)	$ 1,700,875	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,593,828	$ 125,825		$ 87,318	$ (38,507)	$ 1,700,875	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,593,828	$ 125,825		$ 87,318	$ (38,507)	$ 1,700,875	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,593,828	$ 125,825		$ 87,318	$ (38,507)	$ 1,700,875	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,593,828	$ 125,825		$ 87,318	$ (38,507)	$ 1,700,875	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,593,828	$ 125,825		$ 87,318	$ (38,507)	$ 1,700,875	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,593,828	$ 125,825		$ 87,318	$ (38,507)	$ 1,700,875	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,593,828	$ 125,825		$ 87,318	$ (38,507)	$ 1,700,875	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,593,828	$ 125,825		$ 87,318	$ (38,507)	$ 1,700,875	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,593,828	$ 125,825		$ 87,318	$ (38,507)	$ 1,700,875	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1985		$ 20,154	$ 1,048	30	$ 672	$ (376)	$ 10,917	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - ManagCare			1997	2,350	210	20	235	25	1,038	9
10	Allocation - ManagCare			1993	184	-	20	9	9	79	10
11	Allocation - ManagCare			1988	288	9	20	14	5	191	11
12	Allocation - ManagCare			1986	21,796	1,113	8, 20	998	115	17,141	12
13	Allocation - Mazel Management			2001	423	5	20	10	5	10	13
14	Allocation - Mazel Management			2000	214	5	20	11	6	13	14
15	Allocation - Mazel Management			1998	754	26	20	38	12	140	15
16	Allocation - Mazel Management			1997	703	18	20	35	17	152	16
17	Allocation - Mazel Management			1996	479	8	20	24	16	133	17
18	Allocation - Mazel Management			1995	108	3	20	5	2	36	18
19	Allocation - Mazel Management			1994	428	8	20	21	13	138	19
20	Allocation - Mazel Management			1993	253	7	20	13	6	107	20
21	Allocation - Mazel Management			1991	189	6	20	9	3	93	21
22	Allocation - Mazel Management			1990	294	6	20	15	9	167	22
23	Allocation - Mazel Management			1989	184	4	20, 25	8	4	97	23
24	Allocation - Mazel Management			1987	418	8	10, 15	10	2	411	24
25	Allocation - Mazel Management			1986	1,689	88	15, 20	83	(5)	1,360	25
26	Allocation - Mazel Management			1985	118	-	10	-		118	26
27	Allocation - Inter Care, Ltd.			2001	736	105	20	12	(93)	12	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 51,762	$ 2,677		$ 2,222	$ (225)	$ 32,353	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 239,741	$ 30,264	$ 20,667	$ (9,597)	10	$ 100,062	71
72	Current Year Purchases	26,121	5,850	1,577	(4,273)	10	1,577	72
73	Fully Depreciated Assets	174,487	8	8		10	174,445	73
74								74
75	TOTALS	$ 440,349	$ 36,122	$ 22,252	$ (13,870)		$ 276,084	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		TOYOTA CAMRY	1999	$ 20,600	$ 2,950	$ 2,060	$ (890)	5	$ 4,463	76
77		ALLOC-MANAGCARE	1900	9,316	1,363	798	(565)	5	6,360	77
78										78
79										79
80	TOTALS			$ 29,916	$ 4,313	$ 2,858	$ (1,455)		$ 10,823	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,138,085	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 166,260	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 112,428	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (53,832)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,987,782	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: $ 7,280 Description: Beds $6302; Alloc-ManagCare $978
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	1999 Dodge Caravan	$ 299	$ 3,588	17
18					18
19					19
20					20
21	TOTAL		$ 299	$ 3,588	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 15,776	$		$ 15,776	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			462			462	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			42,790			42,790	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						22,764		22,764	13
14	TOTAL			$		$ 59,028	$ 22,764		$ 81,792	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 25,997	$ 26,097	1
2	Cash-Patient Deposits	50,982	50,982	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,096,605	1,096,605	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	158,407	158,407	6
7	Other Prepaid Expenses	7,119	7,119	7
8	Accounts Receivable (owners or related parties)	26,173	26,173	8
9	Other(specify): See supplemental schedule		72,856	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,365,283	$ 1,438,239	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		2,026,000	14
15	Leasehold Improvements, at Historical Cost	512,089	512,089	15
16	Equipment, at Historical Cost	374,907	454,907	16
17	Accumulated Depreciation (book methods)	(402,285)	(2,179,510)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		64,152	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(44,196)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule		8,050	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 484,711	$ 991,492	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,849,994	$ 2,429,731	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,262,018	$ 1,262,019	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	47,682	47,682	28
29	Short-Term Notes Payable	260,450	428,735	29
30	Accrued Salaries Payable	109,597	109,597	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,964	11,964	31
32	Accrued Real Estate Taxes(Sch.IX-B)		140,000	32
33	Accrued Interest Payable	310	9,064	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,011	1,011	35
	Other Current Liabilities(specify):			
36	See supplemental schedule		9,385	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,693,032	$ 2,019,457	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		832,217	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 832,217	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,693,032	$ 2,851,674	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 156,962	$ (421,943)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,849,994	$ 2,429,731	48

*(See instructions.)

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 219,695	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 219,695	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	87,267	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(150,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (62,733)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 156,962	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,271,624	1
2	Discounts and Allowances for all Levels	(215,218)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,056,406	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	107,881	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 107,881	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	49,654	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	62,508	19
20	Radiology and X-Ray	1,174	20
21	Other Medical Services	40,709	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 154,045	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	100	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 100	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	13,981	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,981	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,332,413	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,009,719	31
32	Health Care	1,918,165	32
33	General Administration	1,529,705	33
	B. Capital Expense		
34	Ownership	527,850	34
	C. Ancillary Expense		
35	Special Cost Centers	181,414	35
36	Provider Participation Fee	78,293	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,245,146	40
41	**Income before Income Taxes (line 30 minus line 40)****	87,267	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 87,267	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,048	2,176	$ 59,863	$ 27.51	1
2	Assistant Director of Nursing	195	206	4,522	21.95	2
3	Registered Nurses	22,909	24,271	566,236	23.33	3
4	Licensed Practical Nurses	18,656	20,693	357,113	17.26	4
5	Nurse Aides & Orderlies	51,079	54,790	461,880	8.43	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,814	9,484	110,708	11.67	8
9	Activity Director	2,012	2,067	18,221	8.82	9
10	Activity Assistants	5,624	5,778	50,931	8.81	10
11	Social Service Workers	6,859	7,351	99,496	13.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,344	21,638	171,556	7.93	15
16	Dishwashers					16
17	Maintenance Workers	3,954	4,395	51,949	11.82	17
18	Housekeepers	24,352	26,141	184,397	7.05	18
19	Laundry	10,731	11,447	80,441	7.03	19
20	Administrator	2,520	2,617	84,002	32.10	20
21	Assistant Administrator	1,016	1,120	15,640	13.96	21
22	Other Administrative	3,145	3,145	82,302	26.17	22
23	Office Manager					23
24	Clerical	14,874	16,456	171,296	10.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,914	2,162	21,320	9.86	31
32	Other Health Care(specify)					32
33	Other(specify)	1,856	2,576	99,622	38.67	33
34	TOTAL (lines 1 - 33)	202,901	218,513	$ 2,691,495 *	$ 12.32	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 8,600	01-03	35
36	Medical Director	Monthly	4,800	09-03	36
37	Medical Records Consultant	Monthly	4,032	10-03	37
38	Nurse Consultant	19	1,348	10-03	38
39	Pharmacist Consultant	Monthly	1,275	10-03	39
40	Physical Therapy Consultant	87	4,207	10a-03	40
41	Occupational Therapy Consultant	56	2,672	10a-03	41
42	Respiratory Therapy Consultant	502	20,084	10a-03	42
43	Speech Therapy Consultant	3	144	10a-03	43
44	Activity Consultant	16	807	11-03	44
45	Social Service Consultant	134	7,467	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	816	$ 55,436		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	32	1,048	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	32	$ 1,048		53

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Eli Tropper 01/01/01 -09/09/01	Administrator	None	$ 49,525
Ralph Ricana 1/1/01 - 2/1/01	Administrator	None	4,434
Miron Tabic 08/21/01 - 12/31/01	Administrator	None	30,044
Desiree Maurer	Asst Admin.	None	15,640
See Attached	Other Admin		82,302
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 181,945

B. Administrative - Other

Description	Amount
Management Fees - Inter Care Ltd.	$ 37,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 37,000

C. Professional Services

Vendor/Payee	Type	Amount
ManagCare	Bookkeeping	$ 197,340
Various - See attached	Legal	6,738
Frost Ruttenberg & Rothblatt	Accounting	57,720
Personnel Planners	Unemployment Tax Consult.	2,156
JCAHO	Joint-Commition Consultant	1,950
Urban Real Estate Research	Mortgage Survey	500
Achieve Accreditation	Administrative Consultant	2,445
Econocare	Purchasing Consultant	2,538
Commitment Consulting	A/R Consultant	45,748
Systematic Mgmt Systems	Management Consultant	2,446
American Express	Compliance Consultant	2,138
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 321,719

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,176
Unemployment Compensation Insurance	23,889
FICA Taxes	202,145
Employee Health Insurance	58,314
Employee Meals	20,641
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	4,608
Employee Benefits	214
Christmas Expense	1,989
Employee Pension	7,425
Employee Diability Insurance	2,947
TOTAL (agree to Schedule V, line 22, col.8)	$ 387,348

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	18,482
Health Care Worker Background Check	1,127
(Indicate # of checks performed 161)	
License & Permits	2,435
Dues & Subscriptions	5,688
Promotional Advertising	2,919
Dues & Subscriptions - Bldg Co.	75
Allocations from Related Parties	468
Less: Public Relations Expense	
Non-allowable advertising	(2,919)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,276

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,095
Allocation - ManagCare	557
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,652

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BRIGHTVIEW CARE CENTER # 0030551 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on Long Term Care $8,115**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,421** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **78,293**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **20,641** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees